

STATE OF MICHIGAN
DEPARTMENT OF LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX

Petitioner

File No. 86887-001

v

MERS Premier Health and Welfare Benefit Program
Respondent

**Issued and entered
this 8th day of February 2008
by Ken Ross
Acting Commissioner**

ORDER

**I
PROCEDURAL BACKGROUND**

On January 2, 2008, XXXXX, as authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The matter was accepted on January 10, 2008.

The Municipal Employees' Retirement System of Michigan Premier Health and Welfare Benefit Program (MERS) was notified of the external review and was asked to submit the information used in making its adverse determination. MERS provided the information and documents on January 17, 2008.

The issue in this case can be decided by applying the terms of the MERS Premier Health and Welfare Benefit Program Group Health Coverage Certificate (the certificate), the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues

pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner receives health care benefits from MERS, a multiple employer welfare arrangement, as a covered spouse through her husband's employment with the Village of XXXXX.

The Petitioner had surgery performed by XXXXX, M.D., on March 20, 2007. Dr. XXXXX is a non-preferred provider, i.e., he has not contracted to be in MERS's network. When Dr. XXXXX claims were submitted to MERS, they were paid at the non-preferred (out-of-network) level. The Petitioner appealed. MERS reviewed the claims but affirmed its decision and sent a final adverse determination dated December 13, 2007, to the Petitioner.

III ISSUE

Is MERS required to pay more for the Petitioner's surgery by Dr. XXXXX on March 20, 2007?

IV ANALYSIS

Petitioner's Argument

The Petitioner's authorized representative says Dr. XXXXX had previously performed surgery on the Petitioner and when she experienced recurring incapacitating pain she again sought treatment from him, initially on February 28, 2007. She had another visit in March 2007 and the surgery was scheduled for March 20, 2007.

The Petitioner's health coverage changed from Blue Cross and Blue Shield to MERS effective March 1, 2007, and the Petitioner says there was no time to look for a preferred provider under the new coverage. The Petitioner says she decided to have the surgery by Dr. XXXXX because he was familiar with her case and she wanted to avoid the lengthy delay in getting referrals and scheduling appointments with new network physicians.

The Petitioner's authorized representative also states that he was misled by the MERS representative about out-of-network charges. He says he was not informed that claims from non-preferred providers would be paid based on a "reasonable and customary" amount for services and that the non-preferred providers are not obligated to accept MERS's reduced payment.

The Petitioner believes that since she was in the middle of a course of care when her health care coverage changed, she should not have had to change to a network physician. She wants MERS to cover her March 20, 2007, surgery at the preferred (network) level of benefits.

MERS's Argument

MERS says coverage is based on the network status of a provider. The Petitioner's health plan pays 100% for covered services from preferred providers and 80% of the reasonable and customary charge for covered services from out-of-network providers. If a covered employee elects to receive services from an out-of-network provider, an annual \$250.00 deductible also applies. MERS also points out that the 20% copayment for out-of-network approved charges is capped at \$2,000.00 annually. MERS says its preferred providers have agreed to accept MERS approved amount as payment in full for covered services, while non-preferred (out-of-network) providers do not have agreements with MERS and thus may charge more for their services.

MERS explained that covered medical services from non-preferred providers are paid on a reasonable and customary basis. As defined in the certificate, "reasonable and customary" means

the charge which the Plan Supervisor or its designee has determined does not exceed the general level of charges made by other health care providers for similar Care or Treatment within the same geographical area to treat a similar Injury or Sickness.

In other words, MERS does not pay 80% of the provider's charge for out-of-network services but rather 80% of a reasonable and customary charge for those services. MERS establishes the reasonable and customary charge for a service in a given geographic area by using data from a health information technology company that ranks charges by provider and procedure.

Also, when multiple surgical procedures are performed during the same operative session by the same surgeon (preferred or non-preferred), MERS covers the reasonable and customary approved amount of the major procedure and 50% of any secondary or ancillary procedures.

MERS summarized its processing of the claims for Dr. Morris's surgery in this table.

Surgical Procedure	CPT Code 22855	CPT Code 63075	CPT Code 22554	CPT Code 22845	CPT Code 20931
Provider's Charge	\$ 3,150.00	\$ 5,500.00	\$ 5,250.00	\$ 2,100.00	\$ 525.00
Amount Applied to \$250 annual deductible	173.00	0	0	0	0
Less reasonable and customary reduction	0	816.00	0	0	0
Less multiple procedure reduction	946.00	0	0	425.00	340.50
Petitioner's 20% out-of-network co-pay (up to \$2,000.)	406.20	936.80	657.00	0	0
Benefit Paid by MERS	\$ 1,624.80	\$ 3,747.20	\$ 4,593.00	\$ 1,675.00	\$ 184.50

MERS further says that there is no provision in the certificate that requires it to cover out-of-network services at the in-network benefit level when coverage has transferred from the replaced plan to the MERS Premier plan. MERS says it is the covered individual's decision to continue with care from an out-of-network provider or to transfer care to a preferred provider.

MERS asserts that the medical benefits in this case were correctly paid pursuant to the Village of XXXXX medical plan with MERS.

Commissioner's Review

The Commissioner understands why the Petitioner wished to continue her relationship with Dr. XXXXX and understands her unhappiness because she has incurred out-of-pocket costs for her surgery. However, in this external review the Commissioner is bound by the terms and conditions of the Petitioner's certificate. The Commissioner concludes, after reviewing the certificate and other information submitted, that MERS correctly processed the claims from Dr. XXXXX as shown in the table above.

The Petitioner's certificate includes this provision regarding the consequences of using out-of-network providers (page 30):

The Program has contracted with preferred provider organizations (PPOs), which are networks of health care providers to arrange care to Covered Individuals. * * *

You can obtain services from any health care provider, whether or not the provider is a Preferred Provider. However the Program usually provides greater benefits when services are performed by a Preferred Provider.

While the Petitioner's plan covers non-network provider services, those services are subject to a \$250.00 out-of-network deductible and 20% coinsurance. Further, MERS bases its payment for out-of-network services on a reasonable and customary charge for those services, not on the provider's charge.¹ Also, in the Petitioner's case, the surgery charges were subject to the multiple procedure reduction. Finally, because he is not a preferred provider, Dr. XXXXX could bill the Petitioner for the difference between his charge and the amount MERS paid for his services. The result is that after MERS correctly processed the claims and paid \$11,824.50 of Dr. XXXXX \$16,525.00 charge, the Petitioner remained liable for \$4,700.50 in charges.²

Finally, the Petitioner's authorized representative says that he was not told about "reasonable and customary" charges. However, the *MERS Premier Health – Benefit Guide* does explain (on page 8) the disadvantages of using non-preferred providers:

Non-Preferred (Out-of-Network) Providers

Non-preferred providers have not signed agreements to accept MERS Premier Health's approved amount as payment in full for covered services. You can choose to obtain services from a non-preferred provider, but your co-pay amount will be higher and you are responsible for the difference between MERS Premier Health's payment and the provider's charge. * * *

1. Only one of Dr. XXXXX charges exceeded MERS's reasonable and customary charge for the service.

2. MERS says that Dr. XXXXX subsequently "wrote off" \$2,265.90 of charges, leaving the Petitioner responsible for \$2,434.60.

The Commissioner finds that MERS paid the Petitioner's claims according to the terms and conditions of coverage.

**V
ORDER**

The Commissioner upholds MERS's adverse determination of December 13, 2007. MERS is not required to pay more for the Petitioner's surgery on March 20, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.